UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

PAUL MURPHY, Regional Director of Region 3 of the National Labor Relations Board, for and on behalf of the NATIONAL LABOR RELATIONS BOARD,

Petitioner,

v.

CAYUGA MEDICAL CENTER ,

Respondent.

DECLARATION OF DANIEL SUDILOVSKY

Civil Action No.: 3:17-MC-00004 (TJM)(ATB)

STATE OF NEW YORK)
) ss.:
COUNTY OF TOMPKINS)

I, Dr. Daniel Sudilovsky, declare, upon personal knowledge and under penalty of perjury that the following is true and correct:

1. I am the Chairman of Pathology and Laboratory Medicine, and Medical Director of Laboratories for Cayuga Medical Center ("CMC"). I also serve as the Blood Bank Director for CMC.

2. All units of blood and other blood products for patient infusion are prepared and handled by CMC's Laboratory Department, which I oversee in my capacity as Medical Director for Laboratories. Those units of blood are administered under my license. In addition, under the New York State Department of Health, the Joint Commission (an independent non-profit organization that certifies nearly 21,000 health care organizations in the United States), the Clinical Laboratory Improvement Amendments, and Food and Drug Administration and College of American Pathologists accreditation regulations, I am personally responsible for every person and process that affects any blood product anywhere in CMC and have absolute authority over

the blood transfusion process. It is my duty to ensure safe handling and administration of blood products to ensure patient safety and maintain my own as well as CMC's accreditation.

3. On September 22, 2016, Deb Raupers, Vice President of Patient Services, informed me of an incident involving two nurses who failed to follow established CMC protocol in administering a blood product transfusion. Blood product administration is a high risk procedure that could result in the patient's death if the wrong blood product is erroneously administered.

4. The incident involved two nurses failing to perform the required two-nurse bedside verification process before performing the blood transfusion process. This is a final critical safeguard before hanging the blood product and starting the transfusion. A complaint was made by a patient who recognized the nurses were not following the protocol that the other nurses who performed her previous transfusions had used. This complaint resulted in a subsequent investigation.

5. After receiving facts relating to the investigation, and after much consideration, on September 26, 2016, I drafted an email to Ms. Raupers concluding that "these two individuals should not be in positions in which their duties or functions as nurses could again jeopardize patient safety in our system." A copy of this email is attached as **Exhibit A**.

6. Ms. Raupers never identified the individuals who were involved in the incident by name, and I had no knowledge of who the individuals were during the course of my review of the incident. I evaluated this incident solely on the basis of the violation of procedure and the grave threat posed by the reckless and purposeful failure to follow necessary protocol.

7. As set forth in my email evaluating the situation:

> I can only conclude from these facts that the nurses in this case acted in a wantonly and willfully reckless manner by sidestepping the fail safes of

> our standard operating procedures and endangered this patient's life in doing so. Not following protocol to positively identify the patient prior to transfusion by using stickers on a clipboard at the nursing station rather than the patients arm band at the bedside to identify the patient represents a clear near miss/or potential serious harm scenario. As experienced nurses, represents a particularly egregious infraction and I have little reason to believe that this would not be repeated at some point in the future or that this form of disregard for protocols will not be passed on to less experienced staff, if they are in positions to do so.

8. Based on the two nurses' failure to comply with CMC policy and the continued risk they would pose if reinstated, it would be reckless, and it would put my license at risk to allow these nurses to perform blood transfusions under my license. In an environment where failure to follow protocols can lead to instant death, I will not put my license, CMC, and most important, CMC patients, at risk by allowing these nurses to perform transfusions.

Dated: March 1, 2017

Dr. Daniel Sudilovsky

Sworn to before me this
1 th day of March, 2017.

NOTARY PUBLIC

BETSEY CONNER
Notary Public, State of New York
Appointed in Cayuga Co.
Official #01CO5072278
Commission expires 1/27/2019